September 21, 2014

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Burwell:

The undersigned organizations appreciate the opportunity to comment on the proposed Healthy Indiana Plan (HIP) 2.0 demonstration project, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 2, 2014 with supplemental material submitted on August 21, 2014. We fully support Indiana's decision to accept federal Medicaid funding to provide coverage to newly eligible low-income adults. However, we do have concerns with specific aspects of the demonstration request that should be addressed during the approval process. In addition to these specific concerns, we have a general concern that the HIP 2.0 proposal, like other recently approved demonstrations, is enormously complex and will cause confusion for beneficiaries, providers, plans and be difficult for state workers to administer.

As outlined below, our concerns focus on several areas where the proposal will present barriers for people seeking to enroll in coverage or receive care. These features of the proposal do not further the objectives of the Medicaid program, and therefore should not be approved as part of Indiana's demonstration project.

Premiums

Allowing Indiana to impose premiums in the form of POWER account contributions on people with incomes below the poverty line, including those with little or no income, would set a new and dangerous precedent in the Medicaid program. Indiana is proposing to require HIP 2.0 enrollees to make monthly contributions to their POWER accounts, which are similar to health savings accounts, to help beneficiaries meet HIP 2.0's $2,500 deductible. These monthly contributions must be treated as premiums under section 1916(a)(1) of the Social Security Act.

If approved, Indiana's plan would be the first Medicaid demonstration project approved since the creation of a mandatory group of low-income individuals (under section 1902(a)(10)(A)(i)(VII) of the Social Security Act), which would include premium charges to adults with incomes below 50 percent of the poverty line to pay premiums. Charging premiums to people with very low incomes is not an appropriate use of demonstration authority because experience already shows that premiums decrease enrollment of very low-income beneficiaries.

Premiums have already been shown to limit enrollment of eligible people in HIP. Currently many HIP enrollees (23 percent as reported in the HIP 2012 evaluation) do not have to pay premiums as they have no income. The 2012 HIP evaluation also showed that 17 percent of those found eligible for HIP were never enrolled because they could not pay their initial premium. The original HIP program covered people with incomes up to 200 percent of the poverty line, but well more than half (69 percent) of those who did not enroll because of non-payment had incomes *below* the poverty line. Finally, of those who *did* enroll, 12 percent lost coverage because they failed to pay premiums, and 58 percent of those losing coverage had incomes below the poverty line.

Denial and Delay of Coverage

CMS should reject Indiana's proposal to require premiums before providing coverage and its 6-month lockout period for non-payment of premiums. Indiana's proposal requires individuals to make a premium payment before coverage can begin. Individuals have up to 60 days to make their premium payment. Individuals will remain uninsured during this 60-day period. This delay is a barrier to coverage, which does not further the objectives of the Medicaid program Moreover, for individuals with income below the poverty line, this 60-day period of uninsurance makes little sense as they may know when they apply that the HIP premiums are unaffordable and therefore will want to enroll immediately into HIP Basic, which does not have premiums although it has a more limited benefit package that also includes copayments.

Indiana is proposing to impose a 6-month lockout period on individuals with incomes above the poverty line who fail to pay their premiums. Federal regulations at 42 CFR 447.56(b)(5) state that other than terminating eligibility if individuals fail to pay premiums for 60 days, no further consequences can be applied for non-payment. None of the recently approved expansion demonstrations – Arkansas, Iowa, Michigan and Pennsylvania – include a lockout period for non-payment of premiums, and we urge you to deny this request, which also does not further the objectives of the Medicaid program.

"Choice" of HIP Basic or HIP Plus

Individuals below poverty are not provided an appropriate "choice" for coverage. Given the longstanding and robust body of evidence showing the negative effects the use of premiums and cost sharing have on low-income beneficiaries, we do not believe that the proposed HIP Basic and HIP Plus programs offer a real "choice" to the newly eligible adults. As described above, premiums can lower, if not deter, program participation. Moreover, the use of cost sharing, such as copayments, deter individuals from seeking care, including necessary care. We urge CMS to consider an alternative pathway to HIP Plus for people with income below the poverty line who wish to receive the additional benefits offered in HIP Plus but cannot afford to pay the premiums. One idea would be to make HIP Plus

participation conditioned on utilization of age-appropriate recommended preventative services within a specified period. An alternative pathway such as this is consistent with the recent demonstration approvals in Iowa and Pennsylvania.

Retroactive Eligibility

CMS should deny the state's request to waive retroactive eligibility. Indiana's request to waive retroactive eligibility for the newly eligible low-income adults does not provide any demonstrative value other than to put newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt. None of the recently approved expansion demonstrations – Arkansas, Iowa, Michigan and Pennsylvania – include such a provision, and we urge you to deny this request.

Non-Emergency Medical Transportation

CMS should deny the state's request to waive non-emergency medical transportation (NEMT). The state's request to waive NEMT for the newly eligible low-income adults does not further the objectives of the Medicaid and only serves to limit access to care. We urge you to deny this request, or at the very least, only provide a one-year waiver consistent with the recent approvals in Iowa and Pennsylvania.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

CC: Cynthia Mann, Vikki Wachino, Eliot Fishman

American Cancer Society Cancer Action Network
American Federation of State, County and Municipal Employees
Center on Budget and Policy Priorities
Children's Defense Fund
Community Access National Network
Community Catalyst
Georgetown University Center for Children and Families
HIV Medicine Association
March of Dimes
National Health Care for the Homeless Council
National Health Law Program
National Multiple Sclerosis Society
National Women's Law Center